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The discourse of disability in higher education: insights from a health and social care perspective

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The discourse of disability in higher education: insights from a health and social care perspective

Abstract

This article considers perspectives on student disability in the context of health and social care disciplines in higher education. The first phase of the research, which adopted an appreciative inquiry approach, involved interviews with students and educators from fifteen health and social care professions across the United Kingdom (UK). Findings were used by the Health Care Professions Council (HCPC) to redraft guidance for potential applicants.

The second phase of the research involved analysis of the discourse underpinning the new guidance, which was compared with responses to its publicly open review. Analysis revealed that despite an affirmative stance adopted by the HCPC, the principle of inclusivity for people with a disability remains far from universally and unconditionally accepted.

1. Introduction

More than a billion people (about 15% of the world's population) are estimated to live with some form of disability (based on 2010 global population estimates) (World Health Organisation (WHO) 2011, 7). There are over 11 million people with a limiting long term illness, impairment or disability in the United Kingdom (UK) alone. People with a disability remain significantly less likely to be in employment than those without a disability, and in terms of tertiary education, people with a disability are around three times as likely not to hold any qualifications compared to those without a disability, and around half as likely to hold a degree-level qualification (GOV-UK 2014).

We open our discussion with these stark statistics because it is our contention that higher education has a part to play in altering the social, political and economic climate for people with disabilities. That there are fewer people with disabilities in the workforce or gaining qualifications does not necessarily mean that they lack the required capabilities. It suggests that strategies to increase inclusivity for people with disabilities, may not be working as well as they might. The WHO suggests that academic institutions can:

> remove barriers to the recruitment and participation of students and staff with disabilities; ensure that professional training courses include adequate information about disability, based on human rights principles; and conduct research on the lives of persons with disabilities and on disabling barriers, in consultation with disabled people's organizations (WHO, 2011, 22).

Our aim is to invigorate academic debate and change how the needs of students with disabilities are met in higher education. Specifically, we focus on the issues in opening up educational opportunities in the health and social care professions in the UK. However, the issues are equally as relevant across other disciplines, and internationally, as evident in the literature. Nevertheless we acknowledge that:

> the ideology of inclusive education is implemented in different ways across different contexts and varies with national policies and priorities, which are in turn influenced by a whole range of social, cultural, historical and political issues UNESCO 2011, 15).

Despite the neo-liberal discourse in higher education that is reflected in the drive to prepare students for the world of work, which is a dominant international discourse in higher education (Middlehurst, 2014, 1481), there is a moral imperative to understand the support and guidance needs for people with disabilities wishing to work. This article has two main aims: to address a gap in the limited literature (with the exception of nursing) concerning the experiences of students with disabilities in the health and social care professions, and to remedy the lack of analysis of the wider vocational context's readiness to accept a more inclusive stance.

2. Disability: the concept and context

Disability is a blanket term with multiple interpretations. The International Classification of Functioning, Disability and Health (ICF) framework views disability and function as the outcome of the interaction between health and contextual factors (WHO 2002). The UK Equality Act (HMSO 2010, 4) adopts a medical definition of disability as 'a physical or mental impairment that has a substantial and long term adverse effect on a person's ability to carry out normal day to day activities'. The social model attributes disability to the physical and social barriers within society (Marks 1999). It has been critiqued as homogenising disabilities, that can vary between cases and in intensity over time (Shakespeare 2006). However, we adopted the social model standpoint in the belief that people with disabilities are a heterogeneous group with many different impairment diagnoses, but who all face overlapping experiences of disablement or exclusion (Goodley & Lawthom 2006, 2); disability is socially constructed (Shakespeare, Lezzoni & Groce 2009). Terminology is contentious with all terms being potentially offensive to some. We opt to use 'student with a disability' rather than 'disabled student'.

A decade ago, the UK Government identified the achievement of equality for people with disabilities by 2025 as a key objective (Prime Minister's Strategy Unit 2005). Strengthening anti-discrimination legislation and increasing the employment of people with disabilities were recognised as crucial to promoting change. Legislative changes were arguably piecemeal until the passing of the all encompassing Equality Act in 2010, its purpose being to 'review, simplify and modernise discrimination law' (Government Equalities Office, 2013). All employers are required to comply with the act ostensibly opening up employment in all fields, including the health and social care professions.

3. Professional Regulation

Higher education institutions host qualifying programmes in the health and care professions. However, these programmes also involve substantial periods of work-based learning in National Health Service locations, Social Services, third sector organisations and schools. All of these organisations are required to adhere to the code of practice for academic standards and students with disabilities (Quality Assurance Agency, 2010). Whilst, professional bodies such as the Chartered Society of Physiotherapy, the College of Occupational Therapy and the Society of Radiographers have input into quality, the regulators such as the HCPC, the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) quality assure courses through their approval processes. The professional and regulatory bodies are powerful players in influencing standards of education and ultimate entry to the professions.

The HCPC, which is the regulator at the centre of the research presented here, is responsible for the regulation of sixteen professions including, art therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dietitians, hearing aid dispensers, occupational therapists, operating department practitioners, paramedics, physiotherapists, practitioner

psychologists, prosthetists /orthotists, radiographers, social workers and speech and language therapists. Graduates are required to meet general and profession-specific Standards of Proficiency (HCPC n.d.). The HCPC does not ask registrants to inform them of any disability, rather to declare that their health does not affect their ability to practise safely and effectively (HCPC 2013). Importantly, completion of training does not give automatic entry to the professions. Inclusion and exclusion are part of the HCPC's remit.

Contributing to the debate about increased representation of people with disabilities in health and social care professions, Sin and Fong (2007) argued that this would only be achieved if qualifying courses widened the gateway for participation of students with disabilities. They highlighted the need to review regulations and guidance across the professions in line with legislation. The Disability Rights Commission's (DRC) (2007) investigation into professional regulations, especially fitness to practice requirements for nursing, teaching and social work, noted an often implied link between disabilities, competence and safety, which arguably created negative attitudes towards practitioners with disabilities (Chih 2009). Over seventy separate pieces of legislation and statutory guidance were found that laid down often vague requirements for 'good health' or 'physical and mental fitness'. The report states:

> These regulations have a chilling effect on disabled people, deterring them from entering or remaining in these professions. They drive people underground, where they are reluctant to speak of their disability and do not receive support to which they are entitled; support that could enable them to practice safely and effectively (DRC, 2007: 2).

The GMC has recently updated guidance for the medical profession, aiming its advice predominantly at medical schools but acknowledging that prospective and current students and doctors with disabilities may also find the information helpful (GMC 2015). The NMC

guidance around disability is aimed at students but is less comprehensive and is linked to health and good character declaration advice for approved education institutions (NMC 2010). The HCPC needed to update its guidance in the light of the Equality Act, but was also keen to improve the accessibility and quality of information available to prospective students about the suitability of health and care professions for applicants with disabilities.

4. Higher education and students with disabilities

There is a growing literature about the experience of students with disabilities and support structures in higher education in general, although the impression internationally is one of room for improvement. Holloway's (2001) small-scale qualitative study investigating university experience of students with disabilities in the UK identified the need for a central policy supporting the philosophy of access for all students. Suggested changes included central co-ordination to implement the policy with practical guidelines to departments, ongoing monitoring and evaluation procedures which involve students with disabilities, staff training and awareness, and student advocacy. A larger single-institution study identified considerable variability in inclusive practice across individuals and departments (Fuller, Healey, Bradley & Hall, 2004). Disappointingly, almost a decade on, Vickerman and Blundell's (2010) research found little change in the landscape of higher education for students with disabilities. The headlines identify an ongoing need for institutional commitment to develop support services and barrier-free curricula and more consultation with students. Recommendations for increased inclusivity made by Redpath et al. (2013) mirror previous findings but also highlight a need for staff development specifically with respect to mental health issues.

Recent research on the experiences of twenty students with visual or hearing impairments in Northern Ireland identifies some progress yet is critical of inclusion, widening participation and support initiatives for their failure to challenge taken-for-granted discourses that continue to be constructed around 'ability' (Bryne, 2014). The consequence is a 'proverbial "paradox" of support'. This is said to contribute to the 'constructed negative existential status of disability and processes of "othering"' within which individualised needs based assessment and support continue to be portrayed as a gift or concession' (Bryne, 2014, 131). Boyd (2014) is also critical of current constructions of disability, suggesting that notions of 'duty', 'adjustment' and 'protection', construct discourses of disability as fixed or finite which is not helpful. Focusing specifically on fluctuating hidden disabilities, such as chronic fatigue syndrome, epilepsy and diabetes, which have varying impact on students' day to day activities, she rejects the dominant educational discourses based on diagnosis, categorization and quantifiability.

Gabel and Miskovic (2014, 1145) refer to an 'architecture of containment' by which disability is categorised and dealt with in the name of support, which is also acknowledged by Riddell and Weedon (2014, 45) who see it as 'an administrative convenience justifying exclusion'. However their case study of a student teacher with dyslexia highlights tensions between the stigma of disability and its more positive portrayal celebrating difference rather than deficit, noting that despite institutional commitment to inclusivity, individual lecturers remain skeptical to the more liberal stance, particularly in vocational fields.

5. The experience of students with disabilities on health and social care courses

Just as the proportion of students with disabilities entering higher education in the UK, year on year, is increasing, the number that choose health and social care courses is also increasing. In 2015, the total number of students enrolled on courses in "subjects allied to medicine" was 144,380 students. Of these students 16,820 (11.6%) disclosed a disability (Higher Education Statistics Agency 2015). The literature around their experiences is growing slowly although insight from nursing dominates. Emphasis is placed on the support of students with disabilities making the transition into the practice setting, the nature of reasonable adjustments and the support structures that enable students to succeed. However, a discourse which persists, alongside that of adjustment and accommodation, is one of grudging compliance. Articles tend to foreground the legislation which conspires to force on them students with disabilities and the perceived challenges that they can bring with them. For instance, Griffiths et al. (2010, 132) observe that in their university:

> The disabled student ratio is much higher than 1 in 10 having some form of disability. This poses unique and complex challenges for the faculty and our practice partners. However, under the Disability Discrimination Act [which preceded the Equality Act] the University is required to make reasonable adjustments to meet the needs of disabled students.

The additional work ostensibly created by students with disabilities is quantified in another study which claims that they require twenty per cent more contact time than their non-disabled peers (Tee et al. 2010). Again, in nursing, Hargreaves and Walker (2014, 1748) refer to the 'ways disabled students are managed in practice settings.' Their discussion identifies tensions between:

> inclusive policies, competing needs including patient safety, public confidence and professional regulations [that] mean that adjustments that can be made in an educational environment to appropriately support student learning may prove to be more difficult in placements that provide direct care to the public' (Hargreaves & Walker 2014, 1748).

Risk, fitness to practice and competence are brought together to contrive to introduce an element of doubt to defy even the keenest aspirations of admissions tutors or of potential students. 'Fitness to practice' is a hallmark of registration or licence to practice. However, research suggests that there is a lack of clarity regarding the benchmark that should apply where impairment is a factor' (Hargreaves & Walker 2014, 1749). Debate in medical education is limited, probably due to the recognised social barriers to disclosing a disability, especially given that support initiatives are mentioned in conjunction with the spectre of requirements for competence (Cook, Griffin, Hayden, Hinson & Raven 2012). However, barriers to disclosure and the associated stigma of disability are recognized in the wider literature (Claiborne, Cornforth, Gibson & Smith, 2011; Matthews, 2009), particularly in association with mental health issues (Venville, Street & Fossey, 2013; Martin, 2010).

The literature concerned with higher education experiences of allied health and social care students (from those sixteen professions regulated by the HCPC) is scant by comparison. Research tends to concentrate primarily on professional regulation and associated restrictions applied to health professionals with disabilities (Johnston et al. 2005; Chih 2009) and the education process (Murphy 2011; Stanley et al. 2011; Sharby & Roush 2009; Author 2008; Brown, James & MacKenzie 2006). The educational process is characterized by barriers to

be overcome. For example, a lack of consensus and uncertainty about the level of physical or sensory impairment that is permissible for physiotherapy students was found to create problems at the admission stage (Opie & Taylor, 2008). Professional placements are a source of stress for all students and this is often exacerbated for students with disabilities. Brown, James and MacKenzie (2006) found nursing and occupational therapy students with disabilities simply wished to be treated the same as their peers, which led the majority to not disclose their disability. In a similar study focusing on the clinical experiences of radiographers with dyslexia, students highlighted the importance of an understanding educator (Murphy 2011).

Again issues of disclosure are identified in Baron, Stalker and Phillips' (1996) research in social work training. Students were reluctant to 'declare' an impairment in response to the policies on disability in their institutions, that created problems of 'typification' (global assumptions of impairment are made about individuals). Stanley et al.'s (2011) research in nursing, teaching and social work also identified issues with disclosing disability and the terminology used. Students reported that the term 'disabled person' made them feel incapable and inferior.

Generally, people with disabilities seem to fair no better on health and social care programmes than their counterparts in other disciplines, maybe even encountering greater challenges. However, given that the available research focusing on the professions regulated by the HCPC is limited, is far from representative of all 16 health and care professions and is characterised by small samples sizes, we were presented with an ideal opportunity to advance knowledge about disability and its impact in this specific aspect of higher education.

6. The Research

The research, conducted in two stages, aimed to:

1) Investigate the perspectives of students, admissions tutors, educators, practice placement educators and disability support services on what helps, enables and improves the chances of students with a disability becoming health or social care professionals.
2) Explore the subsequent take up of findings by the UK Health Care Professions Council (HCPC) (who funded the study), and the current discourse of disability in health and social care through the public response to new guidance.

6.1 Stage 1 - Commissioned study to inform new guidance

The initial stage of the research involved investigating the contemporary experience of students with disabilities studying on HCPC approved programmes across the UK, and the views of stakeholders with whom they came into contact. An appreciative inquiry (AI) approach (Cooperrider & Srivastva, 1987) was adopted to avoid focusing largely on problems. AI offered opportunities to 'identify good practice or 'what worked' for students (Discovery), to imagine their situation at its best (Dream), to give them opportunity to voice their suggestions for ways forward (Design)', in order to empower and instigate change (Destiny) (Clouder & King, 2015).

The research team included four students with disabilities as co-researchers as a means of ensuring authenticity and maintaining focus on issues outside of the other researchers' appreciation. The fieldwork, incorporated a stakeholder day with 25 participants, documentary analysis, and 107 telephone interviews, over five months. The perspectives of

students, academics and practice educators across 15 of the16 professions regulated by the HCPC were gained. The one professional group excluded from this extensive list is the Orthoptists who proved to be inaccessible.

Stakeholder day participants were recruited through professional networks, for example, the Chartered Society of Physiotherapy Special Interest Group, and the Higher Education Academy, Disability in Professional Practice, Special Interest Group. The 25 participants included academics and practice educators, five students with various disabilities, a carer and a Communications Support Worker. The day was highly interactive with café style sessions, small group discussions and scenario-based activities. Aspects covered included a critique of the existing guidance available for people with disabilities, understanding the Equality Act, admissions processes, reasonable adjustment, placement experience and transition to employment. Issues identified from these activities informed the development of interview schedules to be used to broaden the insights gained across the diverse professions. For example, the ambiguity about the term 'reasonable adjustment' and the lack of positive role models for people with disabilities were identified as key issues in need of investigation.

Recruitment and selection of interview participants was purposive. Some programmes, such as prosthetics /orthotics, are offered in a very small number of higher education institutions and have a limited number of students. Access was gained through contacting departmental heads, course directors, disability support officers, and in one instance, a professional body. In some cases, whole cohorts of students and recent graduates were contacted through these means, raising awareness of the research across hundreds of students. This approach generated the majority of interviews, with the exception of a few which were the result of

snowballing from one student or graduate to another. Table 1 gives a breakdown of student interview demographics by profession and Table 2 an overview of overall stakeholder interviews by profession.

Table 1 – **Student Interviewee Demographics**

*RG = Recent Graduate

Profession	**Degree awarded**	**Disabled student Current/Past**	**Gender**		**Year of Study**					**Range of disabilities**
			Male	**Female**	**1**	**2**	**3**	**4**	**RG***	
Arts therapists	GDip Dramatherapy	3		3			1		2	Dyslexia, Eating disorder, Visual impairment, Mobility
Biomedical scientists	BSc (Hons) Applied Biomedical Science	2	1	1			2			Dyslexia
Chiropodists / podiatrists	BSc Hons Podiatry	3	1	2		2	1			Dyslexia, Physical, Mobility
Clinical scientists	Certificate of Attainment									
Dietitians	BSc Hons Dietetics	3	1	2		1	1	1	1	Dyslexia, Diabetes, mobility, muscle + physical
Hearing aid dispensers	BSc (Hons) Audiology with Professional Training	3	1	2			2		1	Hearing impairment, Dyslexia, Visual impairment, physical, mobility,
Occupational therapists	BSc (Hons) Occupational Therapy	4		4		1	2		1	Dyslexia, Visual impairment, Hearing impairment,
Operating department practitioners	BSc (Hons) Operating Department Practice OR DipHE Operating Department Practice	5			5					Dyslexia
Orthoptists	BSc (Hons) Orthoptics									
Paramedics	Dip HE Paramedic Science	5				5				Dyslexia
Physiotherapists	BSc (Hons) Physiotherapy	4	1	3		2	1		1	Chronic Fatigue Syndrome, Arthritis, Dyslexia, Hearing impairment,
Practitioner psychologists	PhD Clinical Psychology	3	1	2			1	1	1	Mental Health, Anxiety, Dyslexia
Prosthetists / orthotists	BSc (Hons) Prosthetics and Orthotics	1		1				1		Dyslexia
Radiographers	BSc (Hons) Diagnostic Radiography	4	2	2	1	1	1		1	Dyslexia, Dyspraxia, physical, Synesthesia, Hearing impairment

Social Workers	BA (Hons) Social Work	4	2	2		2	2			Muscle, Complex physical, Dyslexia, Dyspraxia, Visual impairment, mobility
Speech and language therapists	BSc (Hons) Speech and Language Therapy BSc (Hons)	4	2	2		1	2		1	Muscle, Complex physical, Spina Bifida, Dyslexia, Dyspraxia, Visual impairment, physical, mobility
Total		48								

Table 2 – **Total Stakeholder Interviews**

Profession	**Degree awarded**	**Disabled student/ Graduate**	**Interviews with Staff/Admissions/ Disability Support**	**Practice educators**	**employers**	**Total**
Arts therapists	GDip Drama Therapy	3	1	2	**1**	**7**
Biomedical scientists	BSc (Hons) Applied Biomedical Science/	2	2			**4**
Chiropodists / podiatrists	BSc Hons Podiatry	3	2	1		**6**
Clinical scientists	Certificate of Attainment					
Dietitians	BSc Hons Dietetics	3	2	4	**2**	**11**
Hearing aid dispensers	BSc (Hons) Audiology with Professional Training	3	1	3		**7**
Occupational therapists	BSc (Hons) Occupational Therapy	4	2	2		**8**
Operating department practitioners	BSc (Hons) Operating Department Practice OR DipHE Operating Department Practice	5	1	1		**7**
Orthoptists	BSc (Hons) Orthoptics			1		**1**
Paramedics	Dip HE Paramedic Science	5	1			**6**
Physiotherapists	BSc (Hons) Physiotherapy	4	2	1	**1**	**8**
Practitioner psychologists	PhD Clinical Psychology	3	4	3	**2**	**12**
Prosthetists / orthotists	BSc (Hons) Prosthetics and Orthotics	1	1			**2**
Radiographers	BSc (Hons) Diagnostic Radiography	3	1			**2**
Social Workers	BA (Hons) Social Work	4	1	2	**1**	**8**
Speech and	BSc (Hons)	4	3	3	**5**	**15**

language therapists	Speech and Language Therapy BSc (Hons)					
Total		**48**	**24**	**23**	**12**	**107**

Interviews lasted between 20-40 minutes and responses were recorded on response sheets. Student, academic and practice educator guides covered similar questions from different perspectives. For example, the student guide included questions such as 'What helped you settle onto your course?', 'What has worked well for you in doing your course so far?' 'What adjustments have been made to meet your needs'? 'If you could make an experience ideal for you how would it be?' Tutors and practice educators were questioned about their openness to various disabilities within their specific professions, general awareness of students' needs, support processes and potential adjustments, whether disabled students generally accessed the support available and potential improvements that they felt could be made.

One member of the project team performed the initial data coding of interview and stakeholder day data. Codes were checked with the research team who generated and agreed major themes. The analysis was theoretically driven by *a priori* codes (Boyatzis 1998), largely drawn from the specifics of the education process on which the HCPC wanted guidance. However, an inductive analysis occurred simultaneously, providing rich data to underpin many of the ideas that emerged. Themes gave rise to a series of recommendations for changes to the existing guidance that were presented to the HCPC in the form of a final project report.

6.2 Discourse analysis

The second stage of the research occurred eighteen months after the submission of the HCPC report. This stage involved a new conceptual focus to the original research issues (Heaton, 1998), with the use of discourse analysis to answer the following research questions:

1. What discourses of disability are evident in the context of health and social care programmes and the wider professional community?

2. To what extent does the guidance provided by the HCPC represent, reinforce or challenge the discourses?

3. What messages does the research have for health and social care programmes and higher education institutions in general?

The fit between the nature of the primary data that fed into the HCPC report and these research questions was considered sufficiently close to allow secondary analysis (Heaton, 2004). A discourse analysis approach was chosen in part due to its emancipatory agenda and sociopolitical stance (van Dijk, 1993). A wide variety of meanings and institutional ways of thinking are drawn from written and verbal communication, which are a form of social action. Language constructs versions of a social world (Wodak & Krzyzanowski, 2008) and analysis involved exploring several discursive devices including:

- Interpretive repertoires - common sense ways of sense-making or interpreting the world developed from shared knowledge that negates explanation (Weatherell, 1998) - the analyst reads for unspoken assumptions.
- Ideological dilemmas - evident in contradictions in beliefs, values and practices in the text (Billig et al, 1988).

- Positionality - how people position themselves and others to whom they refer in context.

Again, one member of the project team performed the initial analysis of the report, comparing it to the final guidance and to the response to the public consultation and these were discussed by the research team until consensus was reached. We looked for consistencies and inconsistencies, identified where the HCPC had acted on feedback on the public consultation or not, and the extent to which the students' voices and the voices of other stakeholders had influenced the production of the guidance. Finally, we identified the discourses which we believed currently influence the health and social care disciplines in higher education.

6.3Ethical Consideration

The original research had gained full ethical clearance through Coventry University Research Ethics approval process. As it did not involve patients, the National Research Ethics Service (NRES) ruled that it did not require their approval. Given that all documents are in the public domain, further ethical approval was not sought. The British Educational Research Association (BERA) guidelines for ethical research were followed throughout.

7. Emergent discourses of disability

7.1 Revisiting Stage 1 findings

Table 2 provides an overview of the range of input to findings across the professions from the first stage of the research. Analysis of the original research report, eighteen months after writing it, revealed a largely affirmative account of the experiences of people with a disability

already accepted onto HCPC programmes. Furthermore, there were remarkable synergies between the perspectives of students, educators and practice educators. Our aim is to give a flavour of the participants' comments to illustrate key points rather than to claim that these comments are representative of generalizable findings.

The voices of students with disabilities were characterized by a sense of agency and strong aspirations to engage fully in their courses. The extent to which reasonable adjustments were made in response to disclosing a disability and identification of additional needs was on the whole a recurrent theme of positive accommodation. However, disclosure remained a contentious issue highlighting that the stigma of disability is not yet ousted. For example, an Art Psychotherapist suggested, '*there never seemed to be a route to ask for help but I also knew that if I did disclose I would be seen as not ready to practice as a therapist'* [AP 1]. A student suggested '*some people find it difficult to disclose. I have a lot of disabled friends who are so scared of disclosing because of the stigma and because they may not get a job/placement'* [SLT 2]. Stakeholder day delegates were certainly concerned that *'there may be pressure to disclose when people do not want to [do so]'* and a physiotherapy student described disclosure as *'trying'* [P4].

Some students expressed reluctance or were almost apologetic in negotiating support, resonating with Bryne's (2014) research that was critical of support mechanisms which positioned students as recipients of concessions. For example, a Speech and Language Therapy student reflected '*I am never forceful. I never say I deserve this or that*' [SLT 3]. However, a recently graduated Hearing Aid Dispenser was prepared to negotiate, suggesting, '*say when things aren't working – it's a constant negotiation. As long as you've got someone to either email or pop along and see you can change things'* [HAD 1]. At the other extreme,

a student talked of having '*a full and frank discussion'* [SLT 1] about what was required. Generally, students were well informed of their rights and assertive in ensuring that they were observed. Likewise, admissions tutors, academic staff and practice educators appeared to be open to negotiation and proactive in ensuring that adjustments were made where possible.

Furthermore, the research highlighted how practitioners with disabilities bring particular capabilities to their professions 'because of' their disabilities that have been recognized as providing 'added value'. For instance, a social work practice educator with a disability suggested '*I can actually say with credibility "I understand" to kids or parents of kids who have disabilities'* [SW/PE 2] and a Practitioner Psychologist, Practice Educator suggested '*You can inspire and encourage patients/clients as a disabled person*" [PP/PE 3] . It is possible that the added value phenomenon is of particular relevance to people entering the health and social care professions. However, it shows that disability can be viewed positively with a changed mindset.

Students' agency was evident in others ways. They were realistic in that some students may eventually need to seek alternative career pathways or practice in specific environments in which their needs could be met. Recent economic trends mean that finding employment is a challenge for all graduates. However, students with a disability can be strategic about job applications and are certainly aware of the 'two ticks' symbol on adverts and application forms, a sign that UK employers are committed to employing people with disabilities. Students were conscious that if, as applicants, they disclosed a disability and met the basic person specification for the job, they are guaranteed an interview. This was seen as an incentive to disclose a disability, by a graduate hearing aid dispenser who said, '*If I go for a*

job I definitely declare as for one thing it guarantees an interview' [HAD 1] . Overall the discourse was far from one of subjugation, and in agreement with Bryne (2014), we identify positive messages that are not confined to the students' voices but include other stakeholders.

7.2 Take up of findings and emergent discourses

The HCPC's draft guidance, based on the research report, continued an affirmative theme and, in many respects accepted and acted upon our recommendations. Changes made following the public consultation were minor in nature. The new guidance, published in September 2015, is clear and accessible. Immediately apparent is the new title which refers to 'health' and 'disability' (HCPC 2015b) in acknowledgment of the Equality Act (2010) which legitimates long term, fluctuating or recurring conditions (such as diabetes, epilepsy etc) and signifies a broader focus on the fluctuations that characterize some conditions rather than seeing disability as consistent, fixed and finite (Boyd, 2014). In addition, disregarding consultation feedback of the perceived need to identify specific disabilities, the HCPC has maintained its broad focus, essentially avoiding finite categorization previously criticized (Boyd, 2014), in favour of individuality of experience, context and condition as recommended by the research report.

There is recognition of the sensitivities around the use of language, and identification with the social model of disability which acknowledges that environmental, organizational barriers and societal attitudes disable people. Overall, the guidance features affirmative statements reflecting the positionality of the HCPC. For instance, potential applicants are told 'having a health condition or disability should not be seen as a barrier to becoming a health and care

professional' (HCPC, 2015b, 14). Education providers are reminded to 'not make assumptions about whether a student will be able to complete a particular placement' (HCPCb, 2015, 21). Discussion of disclosure includes recognition that this can be a contentious issue and it is at no point associated with declarations of good character. Student voices are evident in statements acknowledging that 'some people may not want to disclose their disability because they are worried about possible discrimination' (HCPCb, 2015, 10). A wide range of examples and case studies are used to illustrate the ways in which people with disabilities have succeeded on their programmes.

Although relatively limited, the consultation on the draft guidance provided a litmus test of wider attitudes to disability and as such gives a flavour of the context of health and social care. A total of 150 responses were received by the HCPC from both individuals and organizations. Over 50% of organizational responses were from education providers. The HCPC's analysis of responses provides a descriptive account of the issues raised and the rationale for its responses to comments. Some suggestions were adopted and where others were not, the HCPC explained why not. Despite positive comments, inevitably respondents wanted more: more examples, more links, and more definitive answers to intractable questions. However, analysis revealed several other discourses, some more explicit than others, identified as: processing disability, consequences of non-disclosure, failure and 'othering', and the 'elephant in the room'.

7.2.1 Processing disability - someone else's problem?

A tidy way to 'deal' with disability is to put in place structural processes by which it can categorised, processed and 'contained' (Gabel & Miskovic, 2014). To some extent categorization is an inevitable and pragmatic response. Although the HCPC rejected the call

to categorise all disabilities by naming them explicitly, overall its advice advocates a structural approach to support specifically through occupational health assessments, which was strengthened in response to consultation feedback. Arguably, reinforcing the role of occupational health services shifts responsibility from academic staff to 'occupational health professionals' when screening for programme admission or employment. This is held in a tension with the acknowledgement that education providers have a responsibility to people with disabilities, signifying a dilemma. Referrals to occupational health provide a legitimate means of academic staff sidestepping decisions and allow disability to be 'dealt with' elsewhere.

7.2.2 Consequences of Non-Disclosure

The consultation drew calls for the strengthening of the guidance with respect to the importance of disclosure both within the university and on placement. Whilst our research report supported disclosure from the students' perspectives, because it is linked to positive experiences of accessing support (Martin, 2010), there is a red flag statement within the consultation response emphasizing 'the consequences of not disclosing a disability' (HCPC 2015a, 11). Respondents associate disclosure with compromising safety of the student, and most importantly the patient. Patient safety is the ultimate trump card that is used to restrict access to, and progression through, programmes, previously highlighted in nursing (Hargreaves & Walker, 2014). The consultation response is imbued with an implicit threat to people with disabilities. Citing patient safety is a protection mechanism for education providers and the professions, which is softened here by mention in the same sentence of concern for 'student safety' (HCPC 2015a, 11). We suggest that this no more than a concessionary statement. Fortunately the guidance makes no such association between disclosure and threats to patient safety, although the sentiment remains.

7.2.3 Failure and 'othering'

Examples and case studies of students' experiences in higher education are included in the definitive guidance as discursive devices to bring it to life. Case studies are useful in that it is difficult to refute stories of personal experience, although some respondents to the consultation believed the examples to be inauthentic, perhaps because they portrayed success. However, interestingly there was a call for the inclusion of examples of negative outcomes on the basis that positive outcomes give the false impression that this is representative of real life. A 'balanced picture' was called for. What is actually being called for appears to be examples of students positioned as deficient in some respect. This reflects the 'binary between 'A' and 'not A' where 'not A' is deficient and identified as the devalued 'other' who does not meet the required standard' (Davies, 2003, 191). The inclusion of a negative example, ostensibly to warn people with disabilities that success is not guaranteed, is patronizing given that the research illustrated that the majority fully appreciate the scale of the challenge. Generic guidance on how to succeed at university certainly does not include examples of failure. In fact, the HCPC expressed satisfaction with the case studies, but the suggested holding up of failure as a warning to others, is salutary.

7.2.4 The Elephant in the Room

Mental health issues create an ideological dilemma for the HCPC (and for higher education) that is the 'elephant in the room'. In other words, it is an important issue of which people are aware, that hovers in the background but is rarely fully addressed. Mental health was specifically mentioned in the guidance. However, 'singling out and potentially discriminating against those with mental health conditions' (HCPC 2015a, 17) was heavily criticised in the consultation on the basis that its fluctuations are no different to those of someone with a physical disability. The inference that people with mental health issues should be treated with

extra caution has previously been deemed inappropriate (DRC, 2007). Simultaneously, mental health issues were thought to receive inadequate attention; many respondents called for explicit reference to specific problems, and for more examples based on the experiences of people with mental health issues.

The research identified some programmes, and indeed some professions, to be more open to admitting people with mental health issues than others, but also identified potential stigma attached to the negative labelling that occurs, which supports previous research (Venville, Street & Fossey, 2013; Martin, 2010). Faced with tensions between talking about mental health and identifying people with mental health issues as constituting a special case, the HCPC withdrew reference to mental health. Although higher education has been charged with the task of 'dispel[ling] myths and fears about mental illness' (Kiuhara & Huefner, 2008, 111), it is clearly an area that needs more work, especially since a substantial proportion of people experience mental health issues at some time in their lives. Therefore our analysis suggests that mental health does constitute a special case. It supports the suggestion made by Redpath et al. (2013) that staff training in this area is urgently needed, and that it requires further research, especially with respect to how it impacts on students' career choices and subsequent success.

8. Conclusions and Implications

This article aimed to address a gap in the limited literature concerning the experiences of students with disabilities in the health and social care professions, a disciplinary area that

could be expected to be supportive of students with disabilities. The research designed to increase understanding of how to more effectively meet their needs has exposed a number of concurrent discourses. Findings are set in a policy context of new guidance published by the HCPC, a major regulatory body, and in wider public attitudes to the inclusion of people with disabilities in these professions. Analysis reveals the extent of the readiness of the wider vocational context to accept a more inclusive stance. The research builds on previous research highlighting tensions between the stigma of disability and a more affirmative stance, and evidence of enduring skepticism despite institutional commitment to inclusivity (Riddell & Weedon, 2014). Specifically, this research identifies affirmative messages in guidance on inclusivity published by the HCPC, which is representative of the voices of disabled students drawn from the first stage of the research. These messages are juxtaposed with more conservative voices emerging from the public consultation showing that despite regulator commitment, grassroots skepticism remains.

Given the HCPC's positioning, there is a powerful and necessary message in the new guidance for course teams, to the professions, and potentially, to other professional regulators of a need for increased openness and inclusivity. Reflecting our research findings, the guidance promotes the view that people with disabilities can succeed in higher education given timely information and appropriate and respectful support. It also emphasizes that people with disabilities can be an asset in the workplace. Two of the student co-researchers, now in employment, confirmed that they thought that the guidance was clear and very informative. One reflected '*I would have found this very helpful when applying for university …as initially I was unsure what support could be offered or what would happen around having anxiety as a potential professional'*.

Our analysis considered the consultation response as a backdrop to the new guidance. It illustrates the presence of varied and wider socially available interpretive repertoires giving rise to discourses of disability which implicitly construct health and social care education. Some of these discourses are evident in existing literature relating to the nursing profession but they have not been specifically discussed in the context of other health and social care professions. They are likely to exist in other countries, and in other disciplines, as they reflect tensions in wider society which will continue to challenge any guidance regardless of its intentions.

A final thought in the spirit of appreciative inquiry is to aim is to 'bridge the best of what is with collective aspiration of what might be' (Cooperrider & Whitney 2005, 29) and to envisage 'destiny'. Our findings lead us to visualize an ideal world in which higher education institutions take responsibility for students with disabilities so that they avoid feeling that they are being 'categorized' and 'processed' in a faceless and dehumanizing way. The aim should be for openness that encourages students to disclose their disabilities without fear of stigma or discrimination and sensitivity to patronizing students or creating a concessionary culture. Whilst students with disabilities are not there to educate others, they can help to develop understandings and challenge people's attitudes and values – given the chance that is arguably a right.

8.1 Recommendations for future research

Fear of people with mental health issues entering some of the professions is clearly an issue deserving attention and is ripe for further research. One of the most important findings of this study was the discourse of ambivalence surrounding students with mental health issues that we suggest higher education cannot afford to disregard.

Publishing guidance is a small step in instigating change and whether or not it makes a difference remains to be seen. Future research might focus on identifying whether or not the gateway to participation for people with disabilities in higher education, has, in fact, been widened.

8.2 Limitations

Our aim has been to make explicit the tacit discourses that shape institutional processes. By adopting an appreciative inquiry approach, the first stage of the research might be critiqued for turning problems and negative responses into positive messages (Patton, 2002). However, by using a discourse approach to further analysis, we believe we have redressed any bias towards overly positive analyses, to consider the meanings and institutional ways of thinking evident through speech and written texts, which so subtly shape social action. The research is situated in the UK and therefore may not have applicability in other countries. Its focus on the health and care professions is also specific, although we envisage that many findings will be transferrable and resonate across other vocational disciplines in particular.

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